Opening Statement of the Honorable Joseph R. Pitts
Subcommittee on Health
Hearing on "Messing with Success: How CMS' Attack on the Part D Program Will Increase Costs and Reduce Choices for Seniors"
February 26, 2014

(As Prepared for Delivery)

The Medicare Part D prescription drug benefit is a government success story.

Last year, nearly 39 million beneficiaries were enrolled in a Part D prescription drug plan (PDP).

Competition and choice have kept premiums stable. In fact, in 2006, the first year the program was in effect, the base beneficiary premium was $32.20 a month. In 2014, the base beneficiary premium is $32.42 – a 22-cent increase over 9 years – and still roughly half of what was originally predicted.

More than 90% of seniors are satisfied with their Part D drug coverage because of this. African-American and Hispanic seniors report even higher levels of satisfaction, at 95% and 94%, respectively.

The program has worked so well because it forces prescription drug plans and providers to compete for Medicare beneficiaries – putting seniors, not Washington, in the driver's seat.

Part D should be the model for future reforms to the Medicare program.

Instead, in its January 6, 2014, proposed rule, the Centers for Medicare and Medicaid Services (CMS) proposes to dismantle the very features of the program that have made it so popular and successful.

CMS has taken it upon itself to interpret the "non-interference" clause in the statute to mean that it can interfere with negotiations between plans and pharmacies. Congress expressly created the clause to prevent CMS from doing what it intends to do in this rule. Yet CMS is choosing to ignore the law. The proposed rule seeks to essentially eliminate preferred pharmacy networks.

A 2013 Milliman study shows that preferred pharmacy networks will save taxpayers $870 million this year and anywhere from $7.9 billion-$9.3 billion over the next 10 years.

CMS itself says that 96% of the Part D claims it reviewed showed seniors saved money at preferred pharmacies, and nearly 25,500 seniors in my district have chosen Part D plans with a preferred pharmacy network. Yet CMS would take that away from them.

Today, the average senior has 35 different plans to choose from this year. This rule would reduce that choice to two plans. 50% of the plans offered today will be gone, and the health care that seniors like may go with it.

Limiting seniors' choices like this will inevitably lead to higher costs. By some estimates, the restriction on the number of plans that can be offered could cause premiums to rise by 10%-20%. Costs to the federal government may increase by $1.2 – 1.6 billion according to a study by Milliman.

How is this beneficial?

I am at a loss to understand why CMS has proposed these changes and what problems with the Part D drug benefit it is attempting to solve.

I don't see how any of these proposals provide tangible benefits to seniors, but I do see more bureaucracy, less choice and competition, and higher costs to both beneficiaries and the federal government in the future if the proposed rule is enacted.

I urge Secretary Sebelius and Administrator Tavenner to rescind this rule.

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